Double Coverage

Chapter 3

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II. DOUBLE COVERAGE DEVELOPMENT AND PROCESSING OF CLAIMS

A. Double Coverage Development

1. All Claims Require Double Coverage *Development*

All claims, regardless of dollar amount, require review or *development* for possible double coverage with the exception of claims for the services of internal resource sharing providers (OPM Part Three, Chapter 2, Section II.C.3.b.) and resource support providers (OPM Part Three, Chapter 2, Section II.A.1.). The TRICARE Managed Care Support (MCS) Contractor must maintain double coverage information in its files. If double coverage is found to exist, the contractor will establish a flag, or other record, on the beneficiary file which indicates coverage by another health plan or program. The information developed regarding that double coverage shall be maintained in a file and may be used for double coverage processing for all family members, and is to be updated based on any subsequent claim which has a positive indication of double coverage for any family member. Once double coverage is established, any subsequent claims (except claims for the services of internal resource sharing and resource support providers) with a negative indication of double coverage are to be developed to document the exact date of termination and which family members were terminated. Likewise, when the contractor does not have positive double coverage information on file for the beneficiary, development as specified below is required.

2. Development Procedures

For other than internal resource sharing or resource support claims, double coverage information must be developed through any means that will provide a documented record. In the case of development to document the existence or absence of other coverage, such documentation must be in writing, in the form of a signed questionnaire or other written document that incorporates a Federal penalty clause (see Section II.B.3.a.(7)). Development undertaken to clarify amounts paid by OHI, statements on a questionnaire, etc., may be by telephone if a complete and written record is made of the individual(s) contacted, the date of the contact, the identity of the contractor staff member making the contact, and the information obtained. On non-network claims, if the requested double coverage information is not received by the contractor within 35 days of the date the contractor requested it, the claim shall be finalized by denial of the claim. The beneficiary shall be told that if the requested information is provided within normal TRICARE timely filing deadlines, the claim can be reopened. If it is known that there is other insurance, controlled development for non-network claims is waived.

B. Processing of Claims

With the exception of claims for the services of resource support and internal resource sharing providers (see paragraph A.1. above), double coverage *development* shall take place prior to payment of a claim as follows:

1. No Evidence of Double Coverage

a. If all four of the following conditions are met, double coverage may be presumed not to exist, and the claim may be processed without further double

coverage *development*. In all other cases, except as allowed under Section II.B.1.b., below, the possibility of payment by double coverage must be *reviewed*.

(1) "NO" is checked in item 14 of Claim Form 2520, items 9 and 11 are blank on the HCFA 1500 Claim Form, or item 50 is blank on the UB-92, or "No" is checked in item 11a of DD Form 2642.

(2) There is no information in the contractor's files which indicates double coverage exists for either the beneficiary or the sponsor.

(3) There is no information on the claim form to suggest the claim could be covered by another health plan or program; e.g., accident, social security disability or end-stage renal disease for possible Medicare coverage.

(4) There is no information on the claim to suggest that the charges have been submitted to, or paid by, other insurance.

b. If *review* or development undertaken in connection with a previous *non-network* claim has led to a conclusion that a beneficiary has no other health insurance (e.g., no positive double coverage questionnaire, no indication of OHI on a past claim, and no other indicator of possible double coverage), and the information upon which the conclusion was based (that there is no OHI) is not more than twelve (12) months old, further development is not necessary in the absence of new evidence indicating the information obtained on previous development may no longer be correct. *Network* claims shall be developed in accordance with the contractor's established development procedures, i.e., retaining the claim under control is not mandatory.

2. Double Coverage is Known

Except as provided in *Section II.B.2.f.* below, in cases in which it is known that double coverage exists, i.e., retaining the claim under control is not mandatory. The claim must be accompanied by evidence of processing by the double coverage plan. If such evidence is not submitted, the claim shall be returned to the beneficiary (for non-participating claims) or the participating provider (for participating claims) with instructions on proper filing. Whether it is an *network* or *non-network* claim, payment must be obtained from the primary insurance coverage or plan. The contractor shall include procedures to ensure this requirement is met in all agreements with its *network* providers of care. If the provider of care is owned or operated by the contractor or is in a clinic or other facility operated by the contractor as an employee or subcontractor, the other health insurance shall also be collected by the contractor or its designee. When the contractor returns a double coverage claim on which it is known TRICARE is secondary, controlled development for *network* claims is waived. The letter used to return the claim must indicate the name of the known double coverage plan. A sample of a suggested letter is shown in Figure 2-3-A-1. If the claim indicates no OHI coverage, but the contractor's file indicates otherwise, a signed statement by the beneficiary or sponsor furnishing the termination date of the other coverage will be necessary for the contractor to inactivate the positive OHI record. It is preferred that any such statement be on an OHI questionnaire, as described in paragraph Section II.B.2.a.(3)(a), below.

a. Acceptable evidence of processing by the double coverage plan is:

(1) A copy of a worksheet, explanation of benefits or letter from the double coverage plan showing action taken on the claim and the amount paid, if any; or

(2) For services which are not a benefit of the double coverage plan, a copy of pages from the insurance policy or benefit handbook issued by the double coverage plan; or

(3) Except for claims on which Medicare is the primary payer, an entry by the provider of the claim form or itemized statement of the amount paid by double coverage plan or an entry by the provider that the amount allowed by the double coverage plan was applied to the OHI deductible or that maximum OHI benefits have been reached.

(a) When there is evidence that other health insurance (OHI) exists, but the provider's entry on the claim form or attachments does not clearly reflect the action taken by the OHI (whether payment or denial), the contractor must return the claim uncontrolled for supporting data.

(b) *When* a zero is entered on the claim form or attached billing without an explanation by the provider, *take the following action:*

1 For hard copy claims submissions, a copy of the denial by the OHI must be obtained. The contractor may return or otherwise pursue development of the claim. The claim will not be denied unless the standard development procedures have failed, i.e., after thirty-five (35) days, if controlled development is pursued.

2 For electronic media claims (EMC) submissions, a zero in the OHI field shall be accepted for claims processing purposes. However, the contractor shall take appropriate action to ensure that a sample of all such claims are audited on a no less than annual basis with verification obtained from the provider to corroborate the submission of a zero OHI payment amount. In addition, no less than annually, the contractor shall audit past EMC submissions to identify all providers who may show a pattern of submissions with OHI payment amounts of zero or of a nominal amount (e.g., $.01, $1.00, $5.00, etc.). All EMC providers who demonstrate a possible pattern of "plugging" nominal OHI payment amounts shall be referred to the contractor's Program Integrity staff for further investigation.

(c) When Medicare is the primary payer, an Explanation of Medicare Benefits (EOMB) is required. This will enable the contractor to determine whether the provider accepted assignment under Medicare; if the provider accepts assignment the provider cannot bill for any difference between the billed charge and the Medicare allowed amount. In addition, it will identify cost-share and deductible amounts as well as any allowable charge reductions.

(4) For double coverage situations which do not involve the routine issuance of an EOB, such as PPO prescription claims, the following may be accepted in lieu of an EOB:

(a) Documentation that the beneficiary belongs to the PPO;

(b) Documentation that there is a liability beyond the amounts paid to the PPO by the primary payor;

(c) Documentation that the liability is specified in the PPO contract; and

(d) Documentation of total liability on the prescription claim.

NOTE:

Copies of itemized pharmacy statements and insurance booklets showing beneficiary liability and/or benefit coverage are sufficient to establish PPO membership, total charges, PPO payment amounts and beneficiary liability in lieu of the EOB for the processing of double coverage claims.

b. Claims initially submitted with only partial evidence of processing by the double coverage plan, (more services listed on the TRICARE claim than on the EOB from the other coverage) may either be developed under control or those services lacking OHI processing evidence denied. Denial without development is an option only if the claim does not require development for any other reason.

c. After controlled development or uncontrolled return, if a claim for individual services is resubmitted without the requested evidence of processing by the double coverage plan or with only partial evidence, the services lacking the OHI evidence shall be denied.

d. When the explanation of benefits from the double coverage plan itemizes more services than billed on the TRICARE claim, process only the services listed on the TRICARE claim.

e. If the other coverage EOB shows that charges were denied as duplicates of a previously processed claim, the contractor must require the EOB from that previously processed claim. If the OHI claim was denied because of failure of the beneficiary to furnish information or take actions which were within his control, the claim should be returned with a notice to the beneficiary that he is responsible for the proper submission of all information and completion of all actions required to process the OHI claim.

f. If the beneficiary has two or more coverages that are primary to TRICARE, and the claim includes evidence of processing by at least one of the primary coverages but not all of them, and the contractor has determined that no TRICARE payment can be made (e.g., a network provider's full negotiated rate has been paid in full by the first primary coverage), the contractor is not required to develop the claim for processing and/or payment by the remaining primary coverages. In such cases the contractor shall process the claim as if there is *only one primary coverage which has already paid.* This will result in zero TRICARE payment, although applicable cost-share and deductible amounts can be credited to the catastrophic cap as appropriate. Except for internal resource sharing or resource support claims, in no case can any TRICARE payment be made without development for processing by all primary coverages.

3. Double Coverage is Questionable

a. If all four of the conditions in Section II.B.1., above, are not met, and there is insufficient information provided with the claim or in the contractor's files to conclude that the existence of OHI is known, as discussed under Section II.B.2., above, the claim shall be developed under controlled development procedures to determine whether double coverage exists for the beneficiary. Whether accomplished by means of a separate Double Coverage Questionnaire or via automated development letter paragraphs, at a minimum, all of the following data elements must be addressed:

(1) Do you have Other Health Insurance coverage? (Yes or No)

(2) Type of coverage (group, private, supplemental, student plan, Medicaid, etc.)

(3) Have you had Other Health Insurance coverage within the past twelve months? (Yes or No)

(4) Does any other member of your family have Other Health Insurance coverage? (Yes or No; if Yes, list all such members)

(5) Has any other member of your family had Other Health Insurance coverage within the past twelve months? (Yes or No; if Yes, list all such members)

(6) For each Other Health Insurance coverage identified above, list:

(a) Insured's name

(b) Insured's SSN

(c) Name of carrier

(d) Carrier's address

(e) Policy/group/plan number

(f) Effective date

(g) Expiration date (if applicable)

(h) List of family members covered, with sex and birth dates (if all family members are not covered, please explain.)

(7) Attestation and penalty clause. The person filling out the form should have his/her attention called to the requirement to read the following statement:

> *"The statements made above are true and correct to the best of my knowledge. I understand that federal laws 18 U.S.C. 287 and 1001 provide for criminal penalties for submitting knowingly or making any false, fictitious or fraudulent statement or claim in any matter within the jurisdiction of any department or agency of the United States. I further understand that copies of*

the laws cited may be obtained from Uniformed Services legal offices, public libraries and many Health Benefits Advisors."

(8) Signature and date.

b. If a contractor becomes aware of the possible existence of OHI through means other than the adjudication of a pending claim (e.g., a provider returns all or a part of TRICARE payment because of payment by OHI), the contractor shall establish an OHI record for the patient and request completion of a double coverage questionnaire. Depending upon the circumstances of the individual occurrence, reopening and adjustment of prior claims and/or a Program Integrity referral may also be appropriate. All affected claims must be adjusted appropriately, although adjustment action may be temporarily deferred at the request of Program Integrity staff if such adjustment would compromise their investigation.

4. DRG-Based System

This also applies to claims from higher volume mental health hospitals and units subject to the TRICARE Inpatient Mental Health Per Diem Payment System that are authorized to bill for institution-based professional services. The contractor must be able to identify OHI payments for all separately-billable components of the inpatient services on a claim. If the OHI EOB does not adequately identify the payments for each separately-billable component, or if claims for their charges are not received, the entire OHI payment is to be applied to the inpatient operating costs.

5. Catastrophic Loss Protection

See Policy Manual, Chapter 13, Section 14.1.

V. GRIEVANCES AND GRIEVANCE PROCESSING

A. Grievances and Grievance Processing

The Contractor shall develop and implement a single automated grievance system, separate and apart from the appeal process. The grievance system shall allow full opportunity for aggrieved parties to seek and obtain an explanation for and/or correction of any perceived failure of an in-system provider, the health care finder, or other Contractor or subcontractor personnel to furnish the level or quality of care and/or service to which the beneficiary may believe he/she is entitled. Any TRICARE beneficiary, sponsor, parent, guardian, or other representative who is aggrieved by any failure or perceived failure of the Contractor, subcontractor or contracted providers of service or care to meet the obligations for timely, quality care and service at appropriate levels may file a grievance. All grievances must be submitted in writing. The subjects of grievances may be, but are not limited to, such issues as *the refusal of a PCM to provide services or to refer a beneficiary to a specialist,* the length of the waiting period to obtain an appointment, undue delays at an office when an appointment has been made, improper level of care, poor quality of care, or other factors which reflect upon the quality of the care provided or the quality and/or timeliness of the service. If the written complaint reveals an appealable issue, the correspondence shall be forwarded to the Contractor's appeals unit for a reconsideration review.

1. Contractor Responsibilities

It is the Contractor's responsibility to conduct an investigation and, if possible, resolve the aggrieved party's problem or concern. In this responsibility the Contractor shall:

a. Ensure that information for filing of grievances is readily available to all beneficiaries within the service area.

b. Maintain a system of receipt, identification, and control which will enable accurate and timely handling. All grievances shall be stamped with the actual date of receipt within three (3) workdays of receipt in the Contractor's custody. The date of receipt shall be counted as the first day.

c. Investigate the grievance and document the results within sixty (60) days of receipt of the grievance. The Contractor shall notify the contracting officer of all grievances not reviewed within sixty (60) days of receipt.

d. Provide interim written response by the thirtieth (30) calendar day after receipt for all grievances not processed to completion by that date.

e. Take positive steps to resolve any problem identified within sixty days of the problem identification. If the problem cannot be resolved within that period of time, the contracting officer or contracting officer's representative shall be informed of the nature of the problem and the expected date of resolution. If there is no resolution to the problem, the Contractor should acknowledge receipt of the grievance and explain to the grievant why the problem cannot be resolved.

f. Written notification of the results of the review shall be submitted to the beneficiary within sixty (60) days of the original receipt of the grievance.

The letter will indicate who the grievant may contact to obtain more information and provide an opportunity to appeal a review decision of the grievance.

g. Ensure the involvement in the grievance review process of appropriate medical personnel, including personnel responsible for the Contractor's quality assurance program in any case where the grievance is related to the quality of medical care or impacts on utilization review activities.

h. Maintain records for all grievances, including copies of the correspondence, the results of the review/investigation and the action taken to resolve any problems which are identified through the grievance.

VIII. PROVIDER RELATIONS

A. General

The MCS contractor is responsible for conducting an effective provider relations program. The program should include such elements as program education and participation incentives for both *network* and *non-network* providers. The MCS contractor should obtain feedback concerning problems encountered by providers and make efforts to correct those within its area of responsibility. Information concerning problems beyond the MCS contractor's scope of responsibility should be sent to *TMA* for review and resolution efforts.

B. Provider Relations Requirements

The MCS contractor shall perform certain minimum functions for providers within its service area. These functions shall include:

1. Provider Certification

Certification as TRICARE providers for both *network* and *non-network* providers as provided in OPM Part Two, Chapter 2, Provider Certification, and the DoD Regulation (6010.8-R). Timely, accurate processing of provider certifications is essential both for timely claims processing and for furthering provider relations and goodwill.

2. Audit/Review Requirements

See OPM Part One, Chapter 1, and OPM Part Two, Chapter 7, for audit procedures for those providers participating in the signature relaxation program.

3. High Volume Provider Contacts

a. Identification of High Volume Providers

On an annual basis, the MCS contractor shall identify the top 5 percent, by dollar volume, of *non-network* institutional providers and professional providers, in each state of the service area. The MCS contractor shall use the claims processed in the past twelve months. If five (5) percent is fewer than five (5) institutional providers and fewer than twenty (20) professional providers then the top five (5) and top twenty (20) in each state should be listed for contact. However, if any of the institutional providers listed billed less than $100,000 of TRICARE beneficiary care, or if the listed professional provider had less than $25,000 of TRICARE billings, they may be omitted from a visit list.

b. Procedures

At least annually, the MCS contractor should contact, for public relations, problem solving, and possible change to *network* PPO status purposes, those *non-network* providers identified as being "high volume" providers of care. MCS contractor representatives should develop information to present to the providers which will be useful and which will promote participation and understanding. In most high volume provider cases, it will be mutually beneficial to the provider and the MCS contractor to explore *network*, preferred provider status. Any providers identified as having serious or repeated problems related to TRICARE shall be contacted irrespective of volume. Providers with significant problems will be contacted as frequently as necessary to resolve the problems.

The high volume (top 5%) institutional providers shall be contacted with at least annual personal visits by a MCS contractor representative. In addition, the MCS contractor's representative shall contact the high volume professional providers. Because of the potential number and the possibility of a very remote provider being involved, MCS contractor may wish to use the telephone for contacts with some professional providers. However, if a provider is consistently having problems, a representative's visit should be considered necessary. If a provider appears repeatedly among the top five (5) percent, a personal visit by a MCS contractor representative should be made at least every two (2) years, not withstanding the use of telephone contact at other times.

c. Provider Informational Services

MCS contractors are required to provide information services to keep all providers within their services area, whether network or non-network, informed of the TRICARE changes and requirements. A quarterly bulletin shall be mailed to all providers, congressional offices and HBAs in the service area. It should provide information on program coverages, claims filing requirements, eligibility requirements, and specifics of problems the MCS contractor is encountering, such as proper itemization. It should periodically reiterate the requirements for signature authorizations, as required in the OPM Part Two, Chapter 1 MCS contractors shall provide a copy of the bulletin to the *TMA* concurrent with distribution.

C. Reporting Requirements

By the thirtieth (30th) day following the close of each contract quarter, the contractor shall *submit a summary contact report (refer to Section IX.C.3.) to the Contracting Officer Representative (COR) at TMA. The report shall include the categories of contacts (high volume providers, Congressional representatives, HBAs, etc.) and the number of contacts per category, e.g., 100 high volume provider visits, 50 HBA contacts. The contractor shall not routinely send the actual visit and contact reports or the internal contractor management monitoring reports to TMA, but shall maintain them at the contractor's office for review by TMA representatives. The contractor shall notify the COR at TMA of any accomplishments, problems, or recommendations and/or requests from a provider that needs special attention at TMA.*

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PART THREE - MCS CONTRACT REQUIREMENTS

I. PROVIDER NETWORK DEVELOPMENT

The managed care support (MCS) contractor shall establish a provider network throughout the Region(s) to support the TRICARE Prime program and to complement MTF capabilities. Nonenrolled TRICARE beneficiaries may use network providers under the TRICARE Extra program. The network shall meet the standards in Section I.B. of this chapter. A final plan detailing all phases of network implementation shall be submitted to the MTF Commanders, Lead Agents, and the Contracting Officer no later than 150 calendar days prior to the initiation of the delivery of health care services. The plan shall address the network development requirements listed below and in OPM Part Three, Chapter 5.

A. Geographic Availability

In each area where the TRICARE Prime Program is offered (TRICARE Prime service area), the contractor shall permit enrollment by beneficiaries under the terms and conditions of OPM Part Three, Chapter 4. Beneficiaries who live outside TRICARE Prime service areas may enroll in TRICARE Prime, however, they must waive the access standards listed in Section I.B.2.c., below.

1. Areas Where Establishment of the TRICARE Prime and TRICARE Extra Programs is Required

At the start of health care delivery, the contractor shall make the TRICARE Prime and TRICARE Extra programs available in all catchment areas (see definition in OPM Part Two, Chapter 11), at all Base Realignment and Closure (BRAC) sites (OPM Part Three, Chapter 5, Addendum A), and in all noncatchment ZIP code areas designated by the Lead Agents (OPM Part Three, Chapter 5). A listing of all ZIP codes and geographic locations associated with MTF catchment areas is available in the Catchment Area Directory published by the Defense Medical Systems Support Center. Where, because of unique circumstances in a catchment area or in areas that become noncatchment areas as a result of base closures, the establishment or continuation of the TRICARE Prime and/or TRICARE Extra Programs is not feasible, the contractor must direct a request for a waiver or delay of this requirement through the Lead Agents to the Contracting Officer for approval. The request must include the Lead Agent's comments and justifying documentation supporting the request for a waiver or delay.

2. Retail Network Pharmacy Service

The contractor shall provide a retail network pharmacy service in the Regions. The retail pharmacy services shall serve all MHS TRICARE/CHAMPUS eligible beneficiaries and Medicare eligible beneficiaries affected by BRAC site closures. The contractor shall provide a pharmacy patient profile system that will support the requirements of OPM Part Two, Chapter 7. Authorized medications and other supplies will be dispensed in accordance with *32 CFR 199.4(d)(3)(vi)*, Prescription Drugs and Medicines, and TRICARE/CHAMPUS Policy Manual, Chapter 7, Section 7.1. Generic drugs listed with an "A" rating in the current Approved Drug Products with Therapeutic Equivalence Evaluations (Orange Book), published by FDA, and generic equivalents of grandfather or Drug Efficacy Study Implementation (DESI) category drugs, are required to be used as substitutes to brand name drugs. See TRICARE/CHAMPUS Policy Manual, Chapter 13, Section 3.6 for all pharmacy services and claims processing requirements.

3. Areas Where Establishment of the TRICARE Prime and TRICARE Extra Programs Is Optional

To the extent that it is cost-effective, the contractor may expand the TRICARE Prime and TRICARE Extra programs to areas not described in paragraph A.1. above. The geographic availability of the TRICARE Extra program may exceed that of the TRICARE Prime program in these areas. For areas where the establishment of TRICARE Prime and Extra Programs is optional, the contractor shall identify the ZIP codes included in the TRICARE Prime and Extra service areas. After the start of health care delivery, any request to establish the TRICARE Prime and TRICARE Extra Programs in noncatchment areas shall be submitted with fully supporting documentation through the Lead Agent to the Contracting Officer for approval.

4. Beneficiary Access to Care

For areas where TRICARE Prime and Extra Programs are not available, the contractor shall establish a telephone service for all MHS beneficiaries as required by OPM Part Three, Chapter 4, Section VI.B., to assist beneficiaries in locating participating providers.

B. Provider Network Requirements and Standards

The contractor shall establish, in consonance with the Lead Agent Requirements (OPM Part Three, Chapter 5) provider networks through contractual arrangements. In areas where DoD-developed/supported provider networks are in existence, the contractor shall offer all existing network providers the opportunity to participate in the contractor's network (subject to the conditions, criteria and standards established for the Regions) prior to allowing participation by any other provider. Network requirements and standards are listed below.

1. Lead Agents and MTF Interface in Provider Network Development

Prior to the contractor finalizing provider contracts, MTF Commanders and the Lead Agents shall be given an opportunity to provide input into the development of the network in their catchment areas. The contractor shall follow the MTF Commander's directions, in consonance with the Lead Agent's Requirements, OPM Part Three, Chapter 5, regarding the priorities for the assignment of enrollees to primary care managers. MTF Commanders have sole authority for granting clinical privileges to resource sharing providers at the MTFs.

2. Standards for Network Providers

Below are network and access to care standards set by the Government. The network shall comply with the more stringent: standards set by the Government or standards proposed by the contractor. Each catchment or noncatchment area where the TRICARE Prime program is established is considered to be a separate service area to which the standards apply. The contractor shall develop and implement a system for continuously monitoring and evaluating network adequacy.

Section 13041). The contractor shall assemble all necessary documentation required by Addendum C for the background checks and forward the documentation to the *office designated by the* administrative contracting officer (ACO) *or to the office designated in the Memorandum of Understanding (see OPM Part Three, Chapter 2, Addendum A).*

a For health care practitioners requiring MTF clinical privileges, the contractor shall furnish completed background check documentation to the MTF commander prior to the award of privileges.

b For individuals who require background checks but not clinical privileges, the contractor shall furnish the completed documentation to the MTF commander prior to employment at, or assignment to, the MTF.

c While waiting the thirty (30) day minimum period for a background check to be completed, the contractor shall follow the Criminal History Background Check Procedures outlined in Addendum C.

2 *Criminal History Checks*

Contractors shall perform criminal history checks on certain physician (see subparagraph a below) and non-physician (see subparagraph b below) network providers. Contractors may search federal, state, and county public records in performing criminal history checks. Contractors may subcontract for these services; for example, MEDI-NET, Inc., provides physician screening services, and ADREM Profiles, Inc., performs criminal history checks. The contractor shall document, in a form of the contractors' choosing, the AMA screen and the results of all criminal history checks.

a Contractors shall screen *their TRICARE* network physicians' licensure and discipline histories using the American Medical Association's (AMA's) master file. *Contractors* shall *check the* criminal histories *of* physicians with anomalies *in their licensure history* [i.e., who have four (4) or more active and/or expired licenses] or who have been disciplined.

b *Contractors also* shall perform criminal history checks on all non-physician providers who practice independently and who are not supervised by a physician (refer to *32 CFR 199.6(c)(3),* for types of providers).

3 The contractor shall maintain a copy of all background check documentation with the provider certification files as required by Addendum B.

4 The contractor is financially responsible for all credentialing requirements, including background checks.

(5) All acute care hospitals in the network shall be members of the National Disaster Medical System (NDMS) network unless it can be shown that they do not qualify for membership.

NOTE:

The Contracting Officer may approve waivers of this requirement on a case-by-case basis. All waiver requests shall be submitted through the Lead Agents to the Contracting Officer.

b. Participation on Claims

All network provider contracts shall require the provider to participate on all claims and submit claims on behalf of all TRICARE and Medicare beneficiaries. *Refer to Section II.A.1.a.(2)(b) for information on claims for emergency and referred care supplied by providers who do not participate.*

(1) Balance Billing

Providers in the contractor's network may only bill TRICARE beneficiaries for applicable deductibles, co-payments, and/or cost-sharing amounts; they may not bill for charges which exceed contractually allowed payment rates. Network providers may only bill MTFs for services provided active duty service members at the contractually agreed amount, or less, and may not bill for charges which exceed the contractually agreed allowed payment amount. The contractor shall include this provision in provider contracts and shall provide the Lead Agents and each MTF Commander with a list of all network providers, their addresses and phone numbers, their specialties or types of service (DME, supplies, etc.), and their contractually agreed allowable amount (discounts or price list) by the tenth (10th) calendar day prior to the start of health care delivery and by the tenth (10th) calendar day prior to the start of each calendar quarter thereafter. (Such lists shall be provided in an electronic or paper format acceptable to the Lead Agent.)

(2) Billing for Non-Covered Services (Hold Harmless)

No payments may be required for any noncovered service which a beneficiary receives from a network provider (i.e., the beneficiary will be held harmless) unless the beneficiary has specifically agreed in advance in writing to pay for the noncovered service. (See OPM Part Three, Chapter 7, Section II.D. for additional details.)

c. Access Standards

The network shall include a complement of civilian providers to ensure access to care for the TRICARE Prime and Extra programs' beneficiaries. Access shall comply with the following guidelines:

(1) Number and Mix of Providers

The network shall include the number and mix of providers, both primary care and specialists, necessary to satisfy demand and to ensure access to all necessary types and levels of primary care. Overall provider availability should be in a ratio of one provider (all physician categories) to every 1,200 TRICARE Prime enrollees. The Primary Care Manager (PCM) requirement is a ratio of one PCM to every 2,000 enrollees. Provider requirements are expressed as full-time equivalents.

(2) Delivery Sites

Except for any special services not sufficiently available in the area to make inclusion in the network practical, the network shall include sufficient delivery sites to ensure access to care. The contractor may request exceptions for a special services not sufficiently available in the area to make inclusion in the network practical. Such requests shall be submitted through the Lead Agent to the Contracting Officer for approval.